EXHIBIT B

General | Financial | Insurance | Activity | Docs & Assign | Mr Cov Part Pages | Cover 360 | PR Billing Info

Scheme: 43939 | 1 | Scheme Name: Wal-Mart Stores, Inc

Member #: 01587522 | Member: ANDREW | L | DAVIS

Tr Ref No: | Employee #: NA | Effective Dt: 10/24/2017

SSN: REDACTED

Member Details | Maintenance | Notes | Refresh | Cancel

Personal Details

Title:

Date of Birth: 03/04/1965

Marital Status: Unknown

Sex: Male

Date Joined Company: 04/30/2002

Product: Prudential Group Insurance

Age: 52

Date Joined Plan: 01/01/2005

Member Group: BEN Beneficiary Only

Status: Active Member - LRK Only

Date of Continuance:

Bill Sort Class:

Employment Status: Regular Full-time Employee

National Insurance No.: 0C0004731

Status Reason: Not Applicable

Continuance End Date:

Passport #: 0E491745W

Billing Group: BEN Beneficiary Only

Billing Branch:

Payroll #:

Annual Salary:

Show SMI

Death Date:

Contact Details

Address: Residential | 5817 COLFAX AVE N.

BROOKLYN CENTER | MN | 554303000

Phone:

Other: Email ID: LIDDELL00LYN@YAHOO.COM

Scheme: 40933 | Scheme Name: Wal-Mart Stores, Inc

Member: ANDREW | L | DAVIS | Member #: 01587522

Member Benefit Options

Effective Dt	Expiry Date	Benefit Type	Nominated Amount	Reason	Bennt
01/01/2005		Basic Life	44000.00	Face Decrease	Stand
01/01/2008		Optional Life	0.00	Delete a Benefit	Stand
09/29/2007	12/31/2007	Optional Life	200000.00	Initial Install	Stand
09/29/2007		Optional Life	200000.00	Initial Install	Stand
01/01/2012		PW Voluntary AD&D Direc	200000.00	Initial Install	Stand

EXHIBIT C

Associate

ANDREW L DAVIS

Date of Birth

REDACTED

Beneficiary Online

Need Help? Call 1-800-421-1362

Beneficiary(ies) for ANDREW L DAVIS Updated On 2015-03-04 at 15.59

COMPANY PAID LIFE INSURANCE
PRIMARY BENEFICIARY(IES)

471435371	JREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTON	MS	39056 US	601-923-8829
475391112	ZREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTEN	MS	39056 US	601-923-8829

BUSINESS TRAVEL ACCIDENT
PRIMARY BENEFICIARY(IES)

471435371	JREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTON	MS	39056 US	601-923-8829
475391112	ZREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTEN	MS	39056 US	601-923-8829

OPTIONAL LIFE INSURANCE
PRIMARY BENEFICIARY(IES)

471435371	JREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTON	MS	39056 US	601-923-8829
475391112	ZREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTEN	MS	39056 US	601-923-8829

ACCIDENTAL DEATH AND DISMEMBERMENT
PRIMARY BENEFICIARY(IES)

471435371	JREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTON	MS	39056 US	601-923-8829
475391112	ZREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTEN	MS	39056 US	601-923-8829

401(k)
PRIMARY BENEFICIARY(IES)

471435371	JREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTON	MS	39056 US	601-923-8829
475391112	ZREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTEN	MS	39056 US	601-923-8829

Allstate Critical Illness
PRIMARY BENEFICIARY(IES)

471435371	JREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTON	MS	39056 US	601-923-8829
475391112	ZREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTEN	MS	39056 US	601-923-8829

Allstate Accident
PRIMARY BENEFICIARY(IES)

471435371	JREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTON	MS	39056 US	601-923-8829
475391112	ZREDACTED BREDACTED	NIECE	50%	227 CASA GRANDE DR	CLINTEN	MS	39056 US	601-923-8829

STOCK OPTIONS

--NO BENEFICIARY(IES)--

Session 8 of 8

First Previous Last Exit

EXHIBIT D

STATE OF MINNESOTA

CERTIFICATION OF VITAL RECORD

CERTIFICATE OF DEATH

STATE FILE NUMBER 2017-MN-035730

DECEDENT	ANDREW LIDDELL DAVIS
LAST NAME BEFORE FIRST MARRIAGE	
ALSO KNOWN AS	
SOCIAL SECURITY NUMBER	REDACTED
SEX	MALE
BORN	REDACTED
PLACE OF BIRTH	NATCHEZ MISSISSIPPI
DATE OF DEATH	OCTOBER 21, 2017
PLACE OF DEATH	NEW HOPE HENNEPIN MINNESOTA
MARITAL STATUS	MARRIED
SPOUSE	MARILYN DAVIS
LAST NAME BEFORE FIRST MARRIAGE	TUQUILAR
RESIDENCE	CRYSTAL HENNEPIN MINNESOTA
PARENT	ANNIE LEE GRANGER
PARENT	LEE ANDREW DAVIS
FUNERAL HOME	BILLMAN-HUNT FUNERAL CHAPEL
DISPOSITION	CREMATION
CAUSE OF DEATH	
IMMEDIATE	CARDIAC ARREST COMPLICATING ALTERCATION
UNDERLYING	
OTHER CONTRIBUTING CONDITIONS	ARTERIOSCLEROTIC AND HYPERTENSIVE CARDIOVASCULAR DISEASE
MANNER	HOMICIDE
MEDICAL CERTIFIER	REBECCA WILCOXON, M.D. HENNEPIN COUNTY MEDICAL EXAMINER'S OFFICE530 CHICAGO AV, MINNEAPOLIS,

THIS RECORD HAS NOT BEEN AMENDED

THIS IS A TRUE AND CORRECT RECORD OF DEATH REGISTERED IN THE MINNESOTA OFFICE OF VITAL RECORDS.

MR&C Certificate ID
11030738

02A-00250444

FILED: OCTOBER 26, 2017

Molly Mulcahy Crawford

Molly Mulcahy Crawford
STATE REGISTRAR

ISSUED: JANUARY 09, 2018 ANOKA COUNTY - VITAL STATISTICS

THIS CERTIFICATE IS VALID ONLY WHEN PRINTED ON OFFICIAL WATERMARKED SECURITY PAPER WITH A SECURITY THREAD AND STATE SEAL OF MINNESOTA.

EXHIBIT E

Prudential

Group Life Insurance Claim Form

Group Insurance
Please send the completed form and all attachments to:
The Prudential Insurance Company of America
Walmart Customer Service
P.O. Box 8517
Philadelphia, PA 19176
Tel: 877-740-2116 Fax: 888-227-6764

1. About You

Provide information about the person making the claim. Make sure to verify your Social Security number (SSN), Tax ID or EIN.

0043939 — Control number (from cover letter provided)
WALMART STORES, INC. — Deceased's employer name

REDACTED — First name
A — MI
REDACTED — Last name

3100 Virginia Ave N — Street address
Apt/Suite (optional)

3100 Virginia Ave N — City
MN — State
55427 — ZIP Code

Crystal — Home phone
Mobile phone
~~Mother~~ niece — Relationship to deceased

~~7632051764~~ Anniedavis2743@gmail.com — Email address
~~Mother~~

REDACTED — Date of birth (mm/dd/yyyy)
REDACTED — Social Security number (SSN), Tax ID or EIN

2. About the Deceased

Provide information about the deceased.

Andrew — First name
L — MI
Davis — Last name

REDACTED — Date of birth (mm/dd/yyyy)
10/21/2017 — Date of death (mm/dd/yyyy)
REDACTED — Social Security Number

3. Tax Certification

Please complete any applicable portions of (a) or (b) below. Make sure to have included your SSN/TIN in Section 1.

(a) Under penalties of perjury, I certify that:

- I am a U.S. *Person* (including resident alien);
- The Social Security/Tax ID number provided in "Section 1" above is my correct SSN/TIN;
- I am not subject to backup withholding due to failure to report interest or dividend income; and
- I am not subject to FATCA reporting.

Check the boxes below, if applicable:

☐ I am subject to backup withholding due to the failure to report interest or dividend income (see "Backup Withholding" in the Tax Certification Information section)

☐ I am subject to FATCA reporting

Prudential

Group Life Insurance Claim Form

Deceased's Social Security Number

3. Tax Certification (continued)

(b) I am not a U.S. Person (including resident alien). I am a citizen of _____.
Attach the applicable IRS Form W-8,(BEN,-BEN-E, ECI. EXP, IMY).

4. Assignment Questionnaire

Will you be assigning the claim to a funeral home, cemetery, or mortuary?

Please Check One: ☒ Yes* ☐ No

*If "yes", please complete the following information, and return this form along with a copy of the Funeral Home Assignment which includes the total amount to be assigned to the funeral home.

Hunts and Billmans
Name of funeral home, cemetery, or mortuary:

612-789-3535
Telephone number Extension

Mailing Address

2701 Central Ave NE
Street address or P.O. Box Apt/Suite (optional)

Minneapolis MN 55418
City State ZIP Code

5. Signature

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have read and understand the terms and requirements of the Claim Fraud Warnings included with this form.

The Internal Revenue Service does not require your consent to any provision in this document other than the certifications required to avoid backup withholding.

REDACTED A B REDACTED 12-18-17
Beneficiary's or Claimant's signature Date (mm/dd/yyyy)

Return this page with the completed form.

Prudential

Group Life Insurance Claim Form

Deceased's Social Security Number

6. Authorization for Release of Information to Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule.

First name	MI	Last name
J REDACTED	A	B REDACTED

Date of birth (mm/dd/yyyy)	Social Security number (SSN), Tax ID or EIN	Relationship to deceased
REDACTED	- -	Niece

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services pertaining to:

First name of deceased	MI	Last name of deceased
Andrew	L	Davis

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to The Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of HIV infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to Prudential.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: (1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (2) obtain reinsurance; (3) administer coverage; and (4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at: P.O. Box 8517, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of my Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release his/her complete medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

Signature of Insured/Patient or Personal Representative	Date (mm/dd/yyyy)
Annie L Davis	12-18-17

Annie L Davis
Please Print Name

Description of Personal Representative's Authority or Relationship to Insured

Return this page with the completed form.

H00806094900000

EXHIBIT F

Prudential

Group Life Insurance Claim Form

Group Insurance
Please send the completed form and all attachments to:
The Prudential Insurance Company of America
Walmart Customer Service
P.O. Box 8517
Philadelphia, PA 19176
Tel: 877-740-2116 Fax: 888-227-6764

1. About You

Provide information about the person making the claim. Make sure to verify your Social Security number (SSN), Tax ID or EIN.

0043939 — Control number (from cover letter provided)
WALMART STORES, INC. — Deceased's employer name

REDACTED — First name
MI
REDACTED — Last name

3100 Virginia Ave No — Street address
Apt/Suite (optional)
310 Virginia Ave N, Crystal — City
MN — State
55427 — ZIP Code

763-205-11764 — Home phone
Mobile phone
Relationship to deceased

763205 11764 — Email address
Nephew

REDACTED — Date of birth (mm/dd/yyyy)
REDACTED — Social Security number (SSN), Tax ID or EIN

2. About the Deceased

Provide information about the deceased.

Andrew — First name
L — MI
Davis — Last name

REDACTED — Date of birth (mm/dd/yyyy)
10/21/2016 — Date of death (mm/dd/yyyy)
REDACTED — Social Security Number

3. Tax Certification

Please complete any applicable portions of (a) or (b) below. Make sure to have included your SSN/TIN in Section 1.

(a) Under penalties of perjury, I certify that:

- I am a U.S. Person (including resident alien);
- The Social Security/Tax ID number provided in "Section 1" above is my correct SSN/TIN;
- I am not subject to backup withholding due to failure to report interest or dividend income; and
- I am not subject to FATCA reporting.

Check the boxes below, if applicable:

- ☐ I am subject to backup withholding due to the failure to report interest or dividend income (see "Backup Withholding" in the Tax Certification Information section)
- ☐ I am subject to FATCA reporting

Return this page with the completed form.

Prudential

Group Life Insurance Claim Form

Deceased's Social Security Number

6. Authorization for Release of Information to Prudential Insurance Company

This Authorization is intended to comply with the HIPAA Privacy Rule.

2 REDACTED | MI | B REDACTED

First name | MI | Last name

REDACTED | REDACTED | nephew

Date of birth (mm/dd/yyyy) | Social Security number (SSN), Tax ID or EIN | Relationship to deceased

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment or services pertaining to:

Andrew | L | Davis

First name of deceased | MI | Last name of deceased

or on my (his/her) behalf ("My Providers") to disclose my (his/her) entire medical record for me or my dependents and any other health information concerning me (him/her) to The Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of HIV infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize all non-health organizations, any insurance company, employer, or other person or institutions to provide any information, data or records relating to credit, financial, earnings, travel, activities or employment history to Prudential.

By my signature below, I acknowledge that any agreements I (he/she) have made to restrict my (his/her) protected health information do not apply to this authorization and I instruct My Providers to release and disclose my (his/her) entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: (1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (2) obtain reinsurance; (3) administer coverage; and (4) conduct other legally permissible activities that relate to any coverage I (he/she) have (has) or have (has) applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at: P.O. Box 8517, Philadelphia, PA 19176. I understand that a revocation is not effective to the extent that any of my Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release his/her complete medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this authorization.

Annie L Davis | 03-27-1947

Signature of Insured/Patient or Personal Representative | Date (mm/dd/yyyy)

Annie L Davis | Guardian

Please Print Name | Description of Personal Representative's Authority or Relationship to Insured

Return this page with the completed form.

Prudential

Group Life Insurance Claim Form

___-___-____
Deceased's Social Security Number

3. Tax Certification (continued)

(b) I am not a U.S. Person (including resident alien). I am a citizen of _____.
Attach the applicable IRS Form W-8 (BEN, BEN-E, ECI, EXP, IMY).

4. Assignment Questionnaire

Will you be assigning the claim to a funeral home, cemetery, or mortuary?

Please Check One: ☒ Yes* ☐ No

*If "yes", please complete the following information, and return this form along with a copy of the Funeral Home Assignment which includes the total amount to be assigned to the funeral home.

Billman Hantz
Name of funeral home, cemetery, or mortuary:

612-789-3535
Telephone number Extension

Mailing Address

3701 Central Ave
Street address or P.O. Box Apt/Suite (optional)

Minneapolis MN 55418-1
City State ZIP Code

5. Signature

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I have read and understand the terms and requirements of the Claim Fraud Warnings included with this form.

The Internal Revenue Service does not require your consent to any provision in this document other than the certifications required to avoid backup withholding.

Annie L Davis 1-17-18
Beneficiary's or Claimant's signature Date (mm/dd/yyyy)

Return this page with the completed form.